DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	Dental Providers Managed Care Plans	**Memorandum No: 05-40 MAA** **Issued: July 1, 2005**
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration (MAA)	**For Information Call:** (800) 562-6188

Subject: **Dental Program (Adults/Children): Fee Schedule Changes**

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2005 relative value units (RVUs);
- A one (1.0) percent vendor rate increase for Children's program only.

Maximum Allowable Fees

MAA is updating the Dental Program fee schedule with Year 2005 RVUs as appropriate. The 2005 Washington State Legislature **appropriated a vendor rate increase of one (1.0) percent** for the 2006 state fiscal year which will be applied to the Children's program only. The maximum allowable fees have been adjusted to reflect these changes.

Attached are updated replacement pages D.16–D.48 and F.5 – F.6 for MAA's current *Dental Program (Adults/Children) Billing Instructions*.

Bill MAA your usual and customary charge.

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4^{th} or 5^{th} digits when applicable) or the entire claim will be denied.

MAA's Provider Issuances

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Dental Fee Schedule for Children

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT)
Column 2: Description/Limitations
Column 3: Prior Auth? Is prior authorization required?
Column 4: Maximum Allowable – Children 0 through 18 years of age.
Column 5: Maximum Allowable – Adults 19 through 20 years of age.

- Always bill your usual and customary fee(s) (not MAA's maximum allowable amount).

- For certain procedures, there are separate reimbursement rates for children (0 through 18 years of age) and clients (19 through 20 years of age). These are indicated in the maximum allowable column in the fee schedule.

Remember: You may bill only after services have been provided, but we must* receive *your bill within 365 days from the date of service.

Unless otherwise specified, MAA uses the descriptions of the ADA codes as listed in the CDT manual.

Diagnostic

Clinical Oral Evaluations

MAA does **not** pay separately for chart or record set-up. The fees for these services are included in MAA's reimbursement for Comprehensive Oral Evaluations (D0150) and Limited Oral Evaluations (D0140).

Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0120	**Periodic oral evaluation** A periodic evaluation is allowed once every six months. A comprehensive examination must precede a periodic oral evaluation by at least six months.	No	$22.22	$22.00
D0140	**Limited oral evaluation** An evaluation limited to a specific oral health problem. A limited examination may also be billed when providing an evaluation for a referral. May not be billed when any prescheduled dental service is provided on the same date- except for palliative treatment and radiographs, necessary to diagnose the emergency condition.	No	20.20	20.00
D0150	**Comprehensive oral evaluation** An initial evaluation allowed once per client, per provider, per clinic and must include: i. A complete dental and medical history and a general health assessment; ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.	No	34.34	27.00

Limited Visual Oral Assessment

This procedure code requires expedited prior authorization. (See page D14 for information on the Expedited Prior Authorization process.)

A limited visual oral health assessment does not replace an oral evaluation by a dentist.

Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9999	**Limited visual oral assessment** **EPA Criteria** When billing for this code (D9999) and placing the **assigned EPA number 870000998** onto the ADA claim form, a dental provider is verifying that one of the following occurred: • An assessment was made to determine the need for sealants to be placed by a dental hygienist; • Triage services were provided; • A public health dental hygienist performed an intraoral screening of soft tissues to assess the need for prophylaxis, sealants, fluoride varnish, or referral for other dental treatments by a dentist; or • In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment. This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the parent or guardian of the results. **Refer to page D.15 for information on Expedited Prior Authorization.**	Yes 870000998	$10.10	$10.00 **DDD clients only**

Radiographs

Doing both a panoramic film and an intraoral complete series is not allowed.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D0210	**Intraoral – complete series** (including bitewings) A complete intraoral series consists of 14 periapicals and one series of 4 bitewings. Complete series radiographs will be allowed only once in a 3-year period.	No	$45.45	$35.00
D0220	**Intraoral periapical – single, first film**	No	8.08	7.00
D0230	**Intraoral periapical – each additional film**	No	2.42	1.50
D0240	**Intraoral – occlusal, film**	No	9.09	7.00
When billing D0270 and D0272 on the same date of service, MAA's total reimbursement amount will not exceed the reimbursement for D0274.				
D0270	**Bitewing – single film** Total of 4 bitewings allowed every 12 months.	No	8.08	6.00
D0272	**Bitewings – 2 films** Total of 4 bitewings allowed every 12 months	No	10.50	7.00
D0274	**Bitewings – 4 films** Total of 4 bitewings allowed every 12 months.	No	12.93	9.00
D0321	**Temporomandibular joint film**	No	51.01	36.78
D0330	**Panoramic film – maxilla and mandible** Allowable for oral surgical purposes only. Not to be used for restoration diagnostic purposes. Documentation must be entered in the client's file. Panoramic-type films are allowed once in a 3-year period. A shorter interval between panoramic radiographs may be allowed for: • Emergent services, with authorization from MAA within 72 hours of the service; **Continued next page.**	No	43.43	27.00

	• Oral surgical with written prior authorization from MAA; • Orthodontic services (see MAA's *Orthodontic Services* Billing Instructions); or • Preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery.			

Test and Laboratory Examination

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0460	**Pulp vitality test** • Allowed one time per day (not per tooth); • For diagnosis of emergency conditions only; and • Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.	No	$1.01	$1.00
D0501	**Histopathologic examination** Histological examination of oral hard/soft tissue.	No	42.84	40.98

Preventive

Prophylaxis (Scaling and coronal polishing)

- No additional allowance will be given for a cavitron or ultrasonic scaling.
- Prophylaxis and topical application of fluoride must be billed separately.
- Not allowed when performed on the same date of service as periodontal scaling or gingivectomy.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1110	**Prophylaxis, adult [age 19 through 20]** Allowed once every 12 months. Prophylaxis for DD clients allowed three times in 12 months.	No	Not Covered	$37.00
D1120	**Prophylaxis [child age 8-18]** Allowed once every six months. Prophylaxis for DD clients allowed three times in 12 months.	No	$23.46 **(8-18 yrs only)**	**Use Code Above**
D1330	**Oral hygiene instructions [child age 0-7]** Allowed once every six months. Includes prophylaxis.	No	13.24 **(0-7 yrs only)**	**Not Covered**

Fluoride Treatments

- Fluoride treatments are not covered as a routine adult service for persons 19-20 years of age. This service requires prior authorization for this age group, unless provided to a DDD client.
- Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1203	**Topical application of fluoride [gel or varnish] (prophylaxis not included) 0-18 yrs of age** Allowed up to three times in a 12-month period. Additional applications may be reimbursed **with prior authorization**.	No	$13.52	**See code below**
D1204	**Topical application of fluoride (prophylaxis not included) 19 through 20 yrs of age for xerostomia only.** Allowed up to three times in a 12-month period.	Yes	**See code above**	$13.52 **High-risk Adults 19-20 years old and DDD clients ONLY**

Other Preventive Services

- Sealants may be applied to occlusal surfaces of primary and permanent maxillary and mandibular first and second molars and lingual pits of teeth 7 and 10.
- Only teeth with no decay will be covered.
- Sealants are restricted to children 0 through 18 years of age.
- The application of pit and fissure sealants will be covered only once per tooth in a 3-year period.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1351	**Topical application of sealants – per tooth** Tooth and surface designations required. Includes glass ionomer sealants.	No	$22.44	**Not Covered**

Space Maintenance

Space maintainers will be allowed as follows:

- To hold space for missing first and/or second primary molars. Space maintainers are allowed for maintaining positioning for permanent teeth for spaces A, B, I, J, K, L, S and T for clients 18 years of age and under.
- No additional allowance will be given on a lingual arch space maintainer for 3 teeth.
- No reimbursement will be allowed for removing retainers.
- Vertical space maintainers are not covered.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1510	**Space maintainer - fixed – unilateral** Allowed only once per quadrant. Quadrant designation required.	No	$81.61	**Not Covered**
D1515	**Space maintainer – fixed – bilateral** Allowed only once per arch. Arch designation required.	No	122.41	**Not Covered**
D1550	**Recementation of space maintainer** Allowed once per quadrant or arch. Quadrant or arch designation required.	No	28.56	**Not Covered**

Restorative

Amalgam Restorations (including polishing)

- Multiple restorations involving the same surface of the same tooth are considered as a single surface and are reimbursed as such.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration and are reimbursed as such.
- Reimbursement for all pit restorations is allowed as though for one surface amalgam.
- Bases and polishing amalgams are included in the allowance for the major restoration.
- Amalgams and resin-based composite restorations are covered only once in a 2-year period. This applies only to the same surface of the same tooth. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a 2-year period requires written justification on claim form and in patient record.
- Amalgam and/or resin build-ups are included in reimbursement for crowns.
- MAA does not cover flowable composites as a restoration.

Procedure Code	Description/Limitation	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2140	**Amalgam – 1 surface, primary or permanent** Tooth and surface designations required.	No	$51.01	$36.04
D2150	**Amalgam – 2 surfaces, primary or permanent** Tooth and surface designations required.	No	63.25	48.38
D2160	**Amalgam – 3 surfaces, primary or permanent** Tooth and surface designations required.	No	71.41	59.67
D2161	**Amalgam – 4 or more surfaces, primary or permanent** Tooth and surface designations required.	No	71.41	70.40

Resin-Based Composite Restorations (Composite/Glass Ionomer)

Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a one or two-surface restoration.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D2330	**Resin-based composite – 1 surface, anterior** Tooth and surface designations required.	No	$60.60	34.68
D2331	**Resin-based composite – 2 surfaces, anterior** Tooth and surface designations required.	No	66.31	52.54
D2332	**Resin-based composite – 3 surfaces, anterior** Tooth and surface designations required.	No	71.41	67.25
D2335	**Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)** Tooth and surface designations required.	No	71.41	79.87
D2390	**Resin-based composite crown, anterior** Tooth designation required.	No	95.95	53.59
D2391	**Resin-based composite – 1 surface, posterior** Tooth and surface designations required.	No	51.01	36.04
D2392	**Resin-based composite – 2 surface, posterior** Tooth and surface designations required.	No	63.25	48.38
D2393	**Resin-based composite – 3 surfaces, posterior** Tooth and surface designations required.	No	71.41	69.83
D2394	**Resin-based composite, 4 or more surfaces, posterior** Tooth and surface designations required.	No	71.41	70.00

Crowns for Children

Use the final seating date, not the preparation date, as the date of service.

Crowns not requiring prior authorization

[WAC 388-535-1230(1)]

- The Medical Assistance Administration (MAA) covers the following crowns for children **without prior authorization**:

  - ✓ Stainless steel. MAA considers these as permanent crowns, and does not cover them as temporary crowns; and

  - ✓ Nonlaboratory resin for primary anterior teeth.

Crowns that require prior authorization

Laboratory Processed Crowns

[WAC 388-535-1230(2)(3)]

- MAA requires prior authorization for the following crowns, which are limited to **single** restorations for permanent anterior maxillary and mandibular teeth 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27:

  - ✓ Resin (laboratory);
  - ✓ Porcelain with ceramic substrate;
  - ✓ Porcelain fused to high noble metal;
  - ✓ Porcelain fused to predominantly base metal; and
  - ✓ Porcelain fused to noble metal.

- MAA does not cover laboratory-processed crowns for posterior teeth.

Radiographs are required by MAA for confirmation that the requested service meets criteria.

Criteria for crowns

[WAC 388-535-1230(4)(5)]

- Criteria for covered crowns as described on the previous page is:

  - ✓ Crowns may be authorized when the crown is medically necessary.

  - ✓ Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if the tooth is crowned. The provider must submit the following client information:

    - ➢ The overall condition of the mouth;
    - ➢ Oral health status;
    - ➢ Client maintenance of good oral health status;
    - ➢ Arch integrity; and
    - ➢ Prognosis of remaining teeth (prognosis of remaining teeth must not be more involved than periodontal case type II).

  - ✓ Anterior teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

- The laboratory-processed crowns described on the previous page are covered:

  - ✓ Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronal restoration;
  - ✓ Only once per permanent tooth in a five-year period;
  - ✓ For endodontically treated anterior teeth only after satisfactory completion of the root canal therapy. Post-endodontic treatment radiographs must be submitted for prior authorization of these crowns.

Note: Endodontic treatment alone is not justification for authorization of a crown.

Reimbursement for crowns

[WAC 388-535-1230(6)]

MAA reimburses only for the covered crowns listed in this section. The reimbursement is full payment. All of the following are included in the reimbursement and must not be billed separately:

- Tooth and soft tissue preparations;
- Amalgam or resin build-ups;
- Temporary crowns;
- Cement bases;
- Insulating bases;
- Impressions;
- Seating; and
- Local anesthesia.

Temporary crowns are included in MAA's total reimbursement for crowns. MAA does not reimburse separately for temporary crowns.

Prior authorization is required for all but one of the following crowns. Payment will be denied for claims without prior authorization. Temporary crowns are included in MAA's total reimbursement for crowns. MAA does not reimburse separately for temporary crowns.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2390	**Resin-based composite crown, anterior** Tooth designation required.	No	$95.95	$53.59
D2710	**Crown – resin (laboratory)** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	151.50	150.00
D2740	**Crown – porcelain/ceramic substrate** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	353.50	309.06
D2750	**Crown – porcelain fused to high noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	353.50	309.06
D2751	**Crown – porcelain fused to predominantly base metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	353.50	309.06
D2752	**Crown – porcelain fused to noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	353.50	309.06

Other Restorative Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2910	**Recement inlay** Tooth designation required.	No	$17.34	$16.81
D2920	**Recement crown** Tooth designation required.	No	20.40	16.81
D2930	**Prefabricated stainless steel crown – primary tooth** Tooth designation required.	No	90.90	53.59
D2931	**Prefabricated stainless steel crown – permanent tooth** Tooth designation required.	No	90.90	80.00
D2933	**Prefabricated stainless steel crown with resin window** Covered for upper anterior primary teeth C through H only. Tooth designation required.	No	106.05	**Not Covered**
D2950	**Core buildup (including pins)** Tooth designation required.	N/A	**Not Covered**	**Not Covered**

Endodontic

Pulpotomy (excluding final restoration)

D3220	**Therapeutic pulpotomy** Covered only as complete procedure, once per tooth. **For primary teeth only.** Tooth designation required.	No	$44.88	$35.73

Root Canal Therapy

- Includes clinical procedures and follow-up care.
- Separate charges are allowable for open and drain and for root canal treatments if the procedures are done on different days.
- **Not covered for primary teeth.**

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3310	**Anterior (excluding final restoration)** Tooth designation required.	No	$252.50	$165.00
D3320	**Bicuspid (excluding final restoration)** Tooth designation required.	No	272.70	200.00
D3330	**Molar (excludes final restoration)** Tooth designation required. Not covered for wisdom teeth.	No	292.90	222.00

Endodontic Retreatment

These three codes are not payable to the provider who did the initial root canal. The provider performing the service(s) must submit pre-treatment and post-treatment radiographs to MAA.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3346	Retreatment of previous root canal therapy – anterior	Yes	$252.20	$165.00
D3347	Retreatment of previous root canal therapy – bicuspid	Yes	272.70	200.00
D3348	Retreatment of previous root canal therapy – molar Not covered for wisdom teeth	Yes	292.90	220.00

Apexification/Recalcification Procedures

Not covered on primary teeth.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3351	**Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc** Tooth designation required.	No	$71.41	$41.21
D3352	**Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** MAA pays up to5 medically necessary visits. Tooth designation required.	No	35.70	26.28

Apexification/Periradicular Services

Not covered on primary teeth				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3410	**Apicoectomy/periradicular surgery – anterior** Tooth designation required.	No	$158.12	$136.61
D3421	**Apicoectomy/periradicular surgery – bicuspid (first root)** Tooth designation required.	No	158.12	136.61
D3425	**Apicoectomy/periradicular surgery – molar (first root)** Tooth designation required.	No	158.12	136.61
D3426	**Apicoectomy/periradicular surgery (each additional root)** Tooth designation required.	No	47.94	46.24
D3430	**Retrograde filling, per root** Only covered if done with apicoectomy. Tooth designation required.	No	46.92	27.33

Other Endodontic Procedures

Anterior primary teeth are not covered				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3950	**Canal preparation and fitting of preformed dowel or post.** MAA covers only the dowel or post portion of this procedure. Payable only once per tooth and may include multiple dowels or posts. Tooth designation required.	No	$25.50	$22.07

Periodontics

Surgical Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant Quadrant designation required.	No	$102.01	$52.54 **DDD clients only**

Non-Surgical Periodontal Service

For CDT codes D4341:

- Allowed for clients 19 through 20 years of age and DDD clients (see page D.5).
- **Not covered for children 0 through 18 years of age.**
- Allowed only when the client has radiographic evidence of periodontal disease.
- There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis.
- Allowed only when the client's clinical condition meets existing periodontal guidelines.
- Allowed once per quadrant in 24-month period, quadrant designation is required.
- Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.
- Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant	No	$26.02 **DDD clients only**	$26.28
D4342	Periodontal scaling and root planing (1-3 teeth, per quadrant)	No	$13.52 **DDD clients only**	13.66

Periodontal Maintenance

- Allowed for DDD clients three times per year;
- Allowed for clients age 19 through 20 years of age every 12 months;
- Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy;
- Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
- Allowed when the client's clinical condition meets existing periodontal guidelines;
- Allowed when periodontal maintenance starts at least 12 months after completion of periodontal scaling and root planing or surgical treatment and paid only at 12-month intervals.
- Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4910	**Periodontal Maintenance** [full mouth – not per quadrant]	No	$50.50 **DDD clients only**	$50.00

Dentures & Partial Dentures for Children

Use the seating date to bill for dentures.

Initial Set of Dentures

[Refer to WAC 388-535-1080(1)(2)]

- The Medical Assistance Administration (MAA) covers for children only one maxillary denture and one mandibular denture per client in a ten-year period, **and considers that set to be the first set**.

- **MAA does not require prior authorization for the first set of dentures.** (See exception for laboratory and professional fees for dentures and partials, page D.36.)

- The first set of dentures may be any of the following:

  - ✓ An immediate set (constructed prior to removal of the teeth);
  - ✓ An initial set (constructed after the client has been without teeth for a period of time); or
  - ✓ A final set (constructed after the client has received immediate or initial dentures).

- The first maxillary denture and the first mandibular denture must be of the structure and quality to be considered the primary set. MAA does not cover transitional or treatment dentures.

Partials [Refer to WAC 388-535-1080(3)]

- MAA covers partials (resin and cast base) once every five years subject to the following limits:

  - ✓ Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and
  - ✓ No partials are covered when they replace wisdom teeth only.

Exception: The exception to this is replacement dentures, which may be allowed as specified under *Replacement of Complete or Partial Dentures*.

Replacement of Complete or Partial Dentures

[Refer to WAC 388-535-1080(4)]

MAA requires prior authorization for replacement dentures or partials requested within one year of the seat date.

- MAA does not require prior authorization for replacement dentures or partials when:

  ✓ The client's existing dentures or partials meet **one of the following conditions**:

  - ➢ No longer serviceable and cannot be relined or rebased; or
  - ➢ Damaged beyond repair; and

  ✓ The client's health would be adversely affected by absence of dentures; and
  ✓ The client has been able to wear dentures successfully; and
  ✓ The dentures or partials meet the criteria of medically necessary.

- Dentures replacing a lost maxillary denture and/or a mandibular denture must not exceed MAA's limit of one set in a ten-year period.

For partial dentures:

✓ Chart the **missing teeth** on the claim form **and** in the client's record; **and**
✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

For complete dentures:

✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

Laboratory and Professional Fees for Dentures and Partials

[Refer to WAC 388-535-1080(5)]

- MAA does not reimburse separately for laboratory and professional fees for dentures and partials. However, MAA may partially reimburse for these fees when the provider obtains prior authorization and the client:

  - ✓ Dies;
  - ✓ Moves from the state;
  - ✓ Cannot be located; or
  - ✓ Does not participate in completing the dentures.

Rebase **[Refer to WAC 388-535-1080(10)(11)]**

MAA covers one rebase in a five-year period; the dentures must be at least three years old.

Billing **[Refer to WAC 388-535-1080(7)(8)(9)]**

- For billing purposes, the provider may use the impression date as the service date for dentures, including partials, only when:

  - ✓ Related dental services including laboratory services were provided during a client's eligible period; and
  - ✓ The client is not eligible at the time of delivery.

- For billing purposes, the provider may use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.

- MAA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

The requirements in this section also apply to overdentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with RCW 18-32.695.

Complete Dentures (including six months post-delivery care)

- The MAA dental program covers one set of dentures in a ten-year period.
- Dentures placed immediately must be of structure and quality to be considered the permanent set. **Transitional dentures are not covered**.
- No additional reimbursement is allowed for denture insertions.

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5110	Complete denture – maxillary (upper)	No	$401.98	$398.00
D5120	Complete lower – mandibular (lower)	No	401.98	398.00
D5130	Immediate denture – maxillary (upper) Appropriate radiographs must be submitted to MAA.	No	401.98	398.00
D5140	Immediate denture – mandibular (lower) Appropriate radiographs must be submitted to MAA.	No	401.98	398.00

Partial Dentures (including six months post-delivery care)

- One partial per arch is covered.
- D5211 and D5212 are covered for one or more teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing three or more teeth per arch, excluding wisdom teeth.
- MAA pays for partials covered by MAA once in five years.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5211	**Maxillary partial denture – resin base** (includes any conventional clasps, rests and teeth)	No	$242.40	$240.40
D5212	**Mandibular partial denture – resin base** (including any conventional clasps, rests and teeth)	No	242.40	240.40
D5213	**Maxillary partial denture – cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth)	No	452.48	448.00
D5214	**Mandibular partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth)	No	452.48	448.00

Lab and Professional Fees for Complete/Partial Dentures

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5899	**Unspecified removable prosthodontic procedure** Laboratory and professional fees may be paid for complete dentures or partial dentures if the patient: • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. **Requires prior authorization from MAA.** When requesting prior authorization, you must attach an invoice listing laboratory prescriptions and fees.	Yes	**By Report**	**By Report**

Adjustments to Dentures and Partials

- No allowance for adjustments for 6 months following placement.
- Adjustments done during this period are included in denture/partial allowance.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5410	**Adjust complete denture – maxillary** (upper)	No	$16.64	$15.76
D5411	**Adjust complete denture – mandibular** (lower)	No	16.64	15.76
D5421	**Adjust partial denture – maxillary** (upper)	No	16.64	15.76
D5422	**Adjust partial denture – mandibular** (lower)	No	16.64	15.76

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	$37.46	$34.68
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	33.30	28.73

Repairs to Partial Dentures

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5610	**Repair resin denture base** Arch designation required.	No	$34.34	$32.58
D5620	**Repair cast framework** Arch designation required	No	48.82	48.34
D5630	**Repair or replace broken clasp** Arch designation required.	No	52.03	48.34
D5640	**Replace broken teeth – per tooth** Use for initial tooth. Tooth designation required.	No	33.30	28.22
D5650	**Add tooth to existing partial denture** Tooth designation required.	No	39.54	36.78
D5660	**Add clasp to existing partial denture** Tooth designation required.	No	48.82	48.34

Denture Rebase Procedures

D5710	**Rebase complete maxillary denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	$192.50	$180.74
D5711	**Rebase complete mandibular denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	192.50	180.74
D5720	**Rebase maxillary partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	124.86	116.64
D5721	**Rebase mandibular partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	124.86	116.64

Denture Relining

- Relines are included in allowance for dentures if service is provided within first six months of placement of dentures.
- Reline of partial or full dentures is not allowed more than once in a 5-year period.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D5750	**Reline complete maxillary denture (laboratory)**	No	$112.37	$105.08
D5751	**Reline complete mandibular denture (laboratory)**	No	112.37	105.08
D5760	**Reline maxillary partial denture (laboratory)**	No	103.01	96.68
D5761	**Reline mandibular partial denture (laboratory)**	No	103.01	96.68

Other Removable Prosthetic Services

D5850	**Tissue conditioning, maxillary** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	$19.77	$18.91
D5851	**Tissue conditioning, mandibular** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	19.77	18..91
D5860	**Overdenture – Complete** Arch designation required.	No	401.98	398.00
D5932	**Obturator prosthesis, definitive**	No	550.43	515.95
D5933	**Obturator prosthesis, modification**	No	121.20	**Not Covered**
D5952	**Speech aid prosthesis, pediatric** Covered for clients 19 and 20 years old for cleft palate.	No	769.97	721.91

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 0-18 yrs	19 –20 yrs

Prosthodontics, Fixed Repairs

Prosthodontics, Fixed Repairs

D6930	**Recement fixed partial denture (bridge)**	No	$34.34	$32.91

Management of Temporomandibular Joint Dysfunction

D7880	**Occlusal orthotic device** **[Allowed for TMJ/TMD or bruxism only.]** Laboratory-processed only. Requires prior authorization. Justification must include diagnosis. Laboratory invoice must be kept in the client's file. The maximum allowance includes all professional fees, lab costs, and all required follow-ups. One appliance allowed in a two-year period. **Use the seat date to bill for occlusal orthotic device.**	**Yes**	**By Report**	**By Report**

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 0-18 yrs	19 –20 yrs

Oral Surgery – Dentists

MAA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

- The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
- Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page D.10; and
- A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	**Coronal remnants deciduous t**	No	$29.29	$33.14
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	58.84	33.14

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Surgical removal of anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation required.	**See Desc.**	$90.90	$65.00
D7220	**Removal of impacted tooth – soft tissue** Tooth designation required.	No	91.81	76.71
D7230	**Removal of impacted tooth – partially bony** Tooth designation required.	No	131.30	120.00
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation required.	No	151.50	140.00
D7241	**Removal of impacted tooth - completely bony**, with unusual surgical complications Allowed only when pathology is present. Tooth designation required.	No	202.0	180.00

Surgical Extractions (Continued)

D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation required.	No	$81.61	$48.34
MAA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]				

Other Surgical Procedures

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus Permanent teeth only. Tooth designation required.	No	$107.11	$78.82
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required; limited to clients 20 years of age and under.	No	156.08	154.53

Adjunctive General Services

Unclassified Treatment

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9110	**Palliative (emergency) treatment of dental pain – minor procedure** Emergency palliative treatment is: • Allowed only when no other definitive treatment is performed on the same day; and • Allowed once per client, per day. Separate charges are allowable for open and drain and for root canal treatment if the procedures are performed on different days. A description of the service must be documented in the client's file.	No	$45.45	$45.00

Anesthesia

- MAA covers general anesthesia, conscious sedation, and parenteral or multiple oral agents for medically necessary dental services as follows:

  - ✓ For treatment of clients of the Division of Developmental Disabilities;
  - ✓ For oral surgery procedures;
  - ✓ When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record.
  - ✓ When the anesthesia is administered by:

    - ➢ An oral surgeon
    - ➢ An anesthesiologist;
    - ➢ A dental anesthesiologist;
    - ➢ A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH);
    - ➢ A dentist who has a conscious sedation permit (for conscious sedation with parenteral or multiple oral agents) issued by DOH that is current at the time the billed service(s) is provided; or
    - ➢ A dentist who has a general anesthesia permit (for deep sedation or general anesthesia) issued by DOH that is current at the time the billed service(s) is provided.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When general anesthesia (including deep sedation) is administered by:

  - ✓ The attending dentist, MAA reimburses at the rate of 50% of the maximum allowable rate.
  - ✓ A provider other than the attending dentist, MAA reimburses at the maximum allowable rate.

- When billing for general anesthesia, show the beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

- MAA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

$102.20 + [TIME UNITS X $20.44] = MAXIMUM ALLOWABLE FEE
Note: Every 15 minute increment or fraction equals 1 time unit.

- Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*).

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9220	**Deep sedation/general anesthesia** When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record. MAA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(A General Anesthesia permit is required to be on file with MAA from the provider/performing provider.)**	No	**By Report**	**By Report**
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide** MAA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	$6.24	$6.18 **DDD clients only**
D9241	**Intravenous conscious sedation/analgesia** Conscious sedation with parenteral agents. **(A Conscious Sedation permit is required to be on file with MAA from the provider/performing provider.)**	No	50.50	50.00

D9248	**Non-intravenous conscious sedation** Conscious sedation with multiple oral agents. **(A Conscious Sedation permit is required to be on file with MAA from the provider/performing provider.)**	No	$50.50	$50.00

Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.
- Mass screening for dental services of clients residing in a facility is not permitted.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9410	**House/extended care facility call** Allowed once per day (not per client and not per facility), per provider.	No	$32.64	$31.53
D9420	**Hospital calls (includes emergency care)** Allowed once per day, per client, per provider. Not covered for routine preoperative and postoperative visits.	No	32.64	31.53

Drugs

D9610	**Therapeutic drug injection.** Antibiotics only. Includes cost of drug.	No	$20.20	$20.00
D9630	**Other drugs and/or medicaments** Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. MAA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	**By Report**	**By Report**

Miscellaneous Services

D9920	**Behavior management** Involves a patient whose documented behavior requires the assistance of **one additional dental professional staff** to protect the patient from self-injury while treatment is rendered.	No	$27.27	$27.00 **DDD clients only**
D9951	**Occlusal adjustment, limited** • Allowed once every 12 months – per quadrant; • Quadrant designation required; and • Is included in the fee for restorations or crowns placed by the same provider.	No	14.28 **13-18 yrs only**	13.66

Oral Surgeons may access the Oral Surgery Fee Schedule for Children and Adults within the Physician-Related Services Fee Schedule using this link.

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